STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	08/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

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F0000	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 07/19/2011. Survey dates: August 29 & 30, 2011 Facility number: 000195 Provider number: 155298 AIM number: 100267690 Survey team: Christi Davidson RN-TC Courtney Hamilton RN Connie Landman RN Diana Zgonc RN (08/29/2011) Census bed type: SNF/NF: 93 Total: 93 Census payor type: Medicare: 8	F0000	Cambridge Manor Healthcare and Rehabilitation's preparation and execution of this Plan of Correction in general, or any corrective action does not constitute an admission or agreement by the facility of the facts alleged or the conclusions set forth in the statement of deficiencies.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Medicaid: 68 Other: 17 Total: 93 Sample: 6 This deficiency reflects state findings cited in accordance with 410 IAC 16.2. Quality review 9/02/11 by Suzanne Williams, RN			
F0241 SS=D	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review, the facility failed to ensure the dignity of residents receiving gastrostomy tube (G-tube) feedings by not pulling the curtain to provide privacy from the roommate and by administering the tube feedings in the hallway in a public area of the facility, for 2 of 3 residents reviewed for G-tube feedings in a total sample of 6 residents. (#13, #59) Findings include: 1. The record for Resident #13 was reviewed on 08/29/11 at 10:30 a.m. Diagnoses included, but were not limited to aphasia, chronic respiratory failure,	F0241	Element #1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?It is the policy of this facility to see that residents recieve care in a manner and environment that maintains or enhances each resident's dignity and respect on an individual basis.Currently, resident #13 recieves all of their care in a private setting. This includes all care related to their feeding tube. If care is provided in the resident's room, the curtain is pulled betwen the beds for privacy even if the door is closed. Currently, resident #59 recieves all of their care in a private setting. This includes all care related to their feeding tube.	09/25/2011

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	encephalopathy, seizure disorder, asthma and gastroesophageal reflux disease. A recapitulation of physician's orders for Resident #13, dated 08/01/2011 through 08/31/2011, indicated, "...Jevity 1.2 - Give 1 can every 4 hours via [by way of] G-tube...." A current Medication Administration Record for Resident #13 indicated, G-tube feedings were administered at 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. During an observation on 08/29/11 at 12:25 p.m., LPN #1 entered Resident #13's room to administer G-tube feedings. LPN #1 shut the resident's door, but did not pull the curtain to maintain resident privacy. Resident #13's roommate was present in the next bed during the administration of the G-tube feeding. During an interview regarding protecting resident privacy during G-tube feeding administration, on 08/29/11 at 12:35 p.m., LPN #1 indicated, "I didn't pull the curtain." 2. The record for Resident #59 was reviewed on 08/29/11 at 1:05 p.m. Diagnoses included, but were not limited		If care is necessary to be administered while resident #59 is in the hall or a common area, resident #59 will be taken to a private setting for care to be given.Element #2: How other residents having the potential to be affected by the same deficient practice will be indentified and what corrective action(s) will be taken.All residents who are fed via feeding tube have the potential to be affected by this findign. A "targeted" list was made of all residents who are fed via feeding tube. These residents will be monitored at least 3 times weekly on various shifts during tube feeding care or use to be certain that complete privacy is provided for the resident. Any breech in this provision for privacy will be correctly immediately. This monitoring will be done by DON or designee. The monitoring will continue until 4 weeks of zero negative findings are realized. After that, random weekly monitorings will continue.Element #3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?At an all staff inservice held on 9/20/2011 and 9/22/2011, the following will be covered: A. Dignity B. Dignity policy C. Reisdent Rights D. Privacy 1. Draping 2. Pulling curtain 3. Unnecessary skin exposureAny staff who fail to comply with the	

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	to profound mental retardation, seizure disorder,gastroesophageal reflux disease, hypertension and Diabetes Mellitus Type II. A recapitulation for Resident #59 dated 08/01/11 through 08/31/11, indicated, "...Glucerna 1.2 at 60 cc/ hr [60 milliliters per hour] continuous per G-tube...." During an observation on 08/29/11 at 12:25 p.m., Resident #59 was sitting in the hallway. LPN #2 was observed lifting the resident's shirt and attaching the tube feed to the G-tube and exposing the resident's abdomen. An interview with LPN #2 on 08/29/11 at 12:30 p.m., indicated she was hooking the resident up to the G-tube feeding. She indicated she started Resident #59's G-tube feeding in the hallway "...because she was just brought out of her room...." An interview with the DON on 08/29/11 at 1:35 p.m., indicated the nursing staff had just been inserviced on dignity. On 08/29/11 at 2:47 p.m., the current policy for resident dignity was requested from the Executive Director (ED). On 08/29/11 at 3:15 p.m., the ED provided a copy of the federal regulation		points of this inservice will be further educated and/or progressively disciplined up to and including termination.Element #4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?At the monthly Quality Assurance meetings, the result of the feeding tube care monitoring byt the DON or designee will be reviewed. Any patterns will be identified. An action plan will be written by a committee appointed by the administrator if necessary. The plan will be monitored by the administrator until resolution.NOTE: Any infraction discovered during the monitoring by the DON or designee will be corrected immediately upon discovery.	

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	regarding dignity and a copy of resident rights. On 08/30/11 at 10:15 a.m., the current facility policy on administering feedings via a G-tube was requested from the ED. An interview with the Administrator on 08/30/11 at 10:00 a.m., indicated LPN #2 thought it would be okay to start the G-tube feeding in the hallway as long as she did not lift the shirt or expose the skin. A facility policy provided by the Executive Director on 08/30/11 at 10:20 a.m. which he indicated was a current policy, titled, "Tube Feedings, Gastrostomy/Jejunostomy," indicated, "...Never over expose Resident [sic] when completing this procedure...2. Bring equipment to bedside...8. Expose G/J tube and drape with towel. NOTE: Do NOT unnecessarily expose the Resident [sic]...." This deficiency was cited on 7/19/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-44(a)(2)			